Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF DISABILITY AND ELDER SERVICES

1 WEST WILSON STREET
P O BOX 7851
MADISON WI 53707-7851

Telephone: (608) 266-2000
FAX: (608) 266-2579
TTY: (608) 266-7376
dhfs.wisconsin.gov

DATE: April 27, 2004

TO: CMO Directors and Financial Managers

FROM: Monica Deignan, Family Care Program Manager
Center for Delivery Systems Development

SUBJECT: Data Certification Forms

Federal Code 42 CFR 438.600 requires that Care Management Organization encounter data and financial statements be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer. This requirement is additionally referenced in the Health and Community Supports Contract, Article X. A., 1. Management Information System (MIS), *MIS Requirements.*

The data certification forms and instructions are attached.

Complete and submit the Encounter Data Certification form, per the instructions, for each accepted encounter submission since January 1, 2004. Also complete the Financial Certification form, per the instructions, for the financial report submitted as part of the quarterly report due May 17, 2004. The Financial Certification form must also be completed for any other financial statements requested by the Department and/or submitted at other intervals.

If you have any questions regarding data certification requirements please send them to the CMO Team mailbox at cmoteam@dhfs.state.wi.us or contact Ann Marie Ott, CMO Contract Administrator, at 608- 261 –7809. Linda Baldowin, CDSD Fiscal Analyst, at 608-261-8885 and your assigned Bureau of Information Systems representative are also available to answer your questions.

If you have questions regarding the delivery of your forms or questions about the status of receipt of the required forms, please contact Paulette Quick at 608-266-3416.

STATE OF WISCONSIN
DIVISION OF DISABILITY AND ELDERLY SERVICES
(4/04)

CENTER FOR DELIVERY SYSTEMS DEVELOPMENT
1 WEST WILSON ST SUITE 518
MADISON WI 53702
PO BOX 7851
MADISON WI 53707-7851

Telephone: (608) 267-7286
FAX: (608) 266-5629

CERTIFICATION INSTRUCTIONS

Encounter Data Certification

This certification requires the responsible party to attest that the submitted Encounter Data is accurate, complete and truthful to the best of his/her knowledge. This is required by Federal Code 42 CFR 438.600 (e.g.) and the Health and Community Supports contract. **It is the responsibility of the responsible party to develop the necessary internal checks, audits, and testing procedures to assure the integrity of the data.**

Certification must be completed **every time** an Encounter Data batch is **accepted** by the State of Wisconsin.

After the CMO is sent the **submission status report** indicating that the CMO's data has been **accepted**, the person responsible for the certification should fill in the **batch #** and complete the form.
Submit the completed form to:

CMO Team
Center for Delivery Systems Development
Division of Disabilities and Elder Services
Department of Health and Family Services
1 West Wilson St., Suite 518
PO Box 7851
Madison, WI 53707-7851

Financial Certification

This certification requires the responsible party to attest that the submitted financial statement is accurate, complete and truthful to the best of his/her knowledge. This is required by Federal Code 42 CFR 438.600 (e.g.) and the Health and Community Supports contract. **It is the responsibility of the responsible party to develop the necessary internal checks, audits, and testing procedures to assure the integrity of the financial statement.**

Certification must be included with submission of the financial statement to the State.
Submit the completed form to:

CMO Team
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Division of Disabilities and Elder Services
Department of Health and Family Services
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PO Box 7851
Madison, WI 53707-7851

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ENCOUNTER DATA CERTIFICATION

Pursuant to the Health and Community Supports contract(s) between the State of Wisconsin, Department of Health and Family Services, Division of Disability and Elder Services, and the _____ Care Management Organization, hereafter known as the CMO. The CMO certifies that: The business entity named on this form is a qualified provider enrolled with and authorized to participate in the Wisconsin Medicaid program as a CMO. The CMO acknowledges that Federal Code 42 CFR 438.600 (e.g.) requires that the data submitted must be certified by a Chief Financial oficer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The CMO hereby requests payment from the Wisconsin Medicaid program based on encounter data submitted and in so doing makes the following certification to the State of Wisconsin as required by Federal Code 42 CFR 438.600 (e.g.).

The CMO has reported to the State of Wisconsin for the month/year of _____ all new encounters included in batch ID# _____. The CMO has reviewed the encounter data for the period and batch listed above and I, _____ (enter Name of Chief Financial Officer, Chief Executive Officer or Name of person who reports directly to and who is authorized to sign for Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to the State of Wisconsin in this batch is accurate, complete, and truthful. No material fact has been omitted from this form.

I, _____ (enter Name of Chief Financial Officer, Chief Executive Officer or Name of person who reports directly to and who is authorized to sign for Chief Financial Officer, Chief Executive Officer) **acknowledge that the information described above may directly affect the calculation of payments to the CMO. I understand that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact.**

_____ _____
SIGNATURE - NAME AND TITLE OF CFO, CEO OR DELEGATE **DATE SIGNED**

ON BEHALF OF

_____ _____
CMO NAME **DATE SIGNED**

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DIVISION OF DISABILITY AND ELDERLY SERVICES
(4/04)

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MADISON WI 53707-7851

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FINANCIAL STATEMENT CERTIFICATION

Pursuant to the Health and Community Supports contract(s) between the State of Wisconsin, Department of Health and Family Services, Division of Disability and Elder Services, and the _____ Care Management Organization, hereafter referred to as the CMO. The CMO certifies that: The business entity named on this form is a qualified provider enrolled with and authorized to participate in the Wisconsin Medicaid program as a CMO. The CMO acknowledges that if payment is based on any information required by the State and contained in financial statements, Federal Code 42 CFR 438.600 (e.g.) requires that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The CMO hereby requests payment from the Wisconsin Medicaid program based on any information required by the State and contained in financial statements submitted and in so doing makes the following certification to the State of Wisconsin as required by Federal Code 42 CFR 438.600 (e.g.).

The CMO has reported to the State of Wisconsin for the period of _____ (indicate dates) all information required by the State and contained in financial statements. The CMO has reviewed the information submitted for the period listed above and I, _____ (enter Name of Chief Financial Officer, Chief Executive Officer or Name of person who reports directly to and who is authorized to sign for Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to the State of Wisconsin in this batch is accurate, complete, and truthful. No material fact has been omitted from this form.

I, _____ (enter Name of Chief Financial Officer, Chief Executive Officer or Name of person who reports directly to and who is authorized to sign for Chief Financial Officer, Chief Executive Officer) **acknowledge that the information described above may directly affect the calculation of payments to the CMO. I understand that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact.**

_____ _____
SIGNATURE - NAME AND TITLE OF CFO, CEO OR DELEGATE **DATE SIGNED**

ON BEHALF OF

_____ _____
CMO NAME **DATE SIGNED**